IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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PHONE 208-334-6626
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CERTIFIED MAIL: 7000 1670 0011 3314 9108

August 16, 2006

Joe F. Rudd Jr., Administrator
Marquis Care at Shaw Mountain
909 Reserve Street
Boise, ID 83712

Provider #: 135090

Dear Mr. Rudd Jr:

On **August 2, 2006**, a Recertification survey was conducted at Marquis Care at Shaw Mountain by the Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency in your facility to constitute immediate jeopardy to several residents' health and safety. You were informed of the immediate jeopardy situations in writing on **July 26, 2006**.

On **July 27, 2006**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the resident had been removed. On August 9, 2006, the facility was informed in writing that after further review, it was determined that the facility's first Plan of Correction would not work in reality and that a new plan was required. The facility was given until today, August 16, 2006, to submit that revised plan. A revised plan has not been submitted as of this writing.

The deficiencies as identified on the revised CMS Form 2567L remain and require a Plan of Correction. The most serious deficiency now constitutes actual harm that is not immediate jeopardy and that is pattern in scope, as evidenced by the CMS Form 2567L, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance.** After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 29, 2006**. Failure to submit an acceptable PoC by **August 29, 2006**, may result in the imposition of additional civil monetary penalties by **September 18, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Based on the immediate jeopardy **F518 -- S/S: K -- 483.75(m)(2) -- Disaster and Emergency Preparedness, and; F315 - S/S: H -- 483.25(d)-- Urinary Incontinence were** cited during this survey, we are recommending to the CMS Regional Office that the following remedies be imposed:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

A 'per instance' civil money penalty of **$5,000.00**.

(THIS REMEDY IS GENERALLY RESERVED FOR SITUATIONS OF SERIOUS NONCOMPLIANCE AS DESCRIBED AT §7510) (§488.430)

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 2, 2007**, if substantial compliance is not achieved by that time.

Your facility's noncompliance with the following:

F315 -- S/S: H -- 483.25(d) -- Urinary Incontinence

has been determined to constitute substandard quality of care as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) require that the attending physician of each resident who was found to have received substandard quality of care as well as the State board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents # **1,2,3,7, and 8** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

This request must be received by **August 29, 2006**. If your request for informal dispute resolution is received after **August 29, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

STATE ACTIONS effective with the date of this letter (**August 16, 2006**):

Due to the serious nature of the deficiencies at **C795 and C239**, the Department is placing the facility on a **Provisional License**. Enclosed is Skilled Nursing Facility License #8. This license is effective through **February 16, 2007**. The conditions of the Provisional License are as follows:

1. Correction of all the deficiencies.

2. The facility must obtain weekly consultation from a qualified professional who is not an employee of the facility. The consultant must be physically present in the facility for a minimum of twenty (20) hours per week. The consultant must provide weekly reports to this office, indicating each deficient area has been reviewed, and corrective actions taken, and the current status of each deficient area. A corporate consultant may fill this requirement.

3. A ban on all admission is being placed on the facility, effective the date of this letter, in accordance with *Title 3, Chapter 12, Rules Governing Long Term Provider Remedies in Idaho*, Section 16.03.12.004.08, which allows additional remedies when non-compliance with program requirements is found.

   IDAPA Section 16.03.12.004.08., states:

   08. Ban on Admissions. Such bans to the facility or to any part thereof shall remain in effect until the State Survey Agency determines that the facility has achieved substantial compliance with all program requirements or until a substitute remedy is imposed.

Failure to comply with the conditions of the Provisional License may result in revocation of the facility's license. *IDAPA 16.03.02.003.05.a.* states:

a. Additional causes for denial of a license may include the following:

   I. The applicant has violated any conditions of a Provisional License.

Please be advised that you are entitled to request an administrative review regarding the issuance of the Provisional License. In order to be entitled to an administrative review, you must submit a

written request to the State Survey Agency within fourteen (14) days from the date upon which you received this letter. The request must state the grounds for the facility's contention that Provisional License was inappropriate. Because a Provisional License may be issued whenever a facility is in substantial compliance with but does not meet every requirement or rule, during the review, you would be expected to demonstrate that none of the findings of deficiency were justified.

In any administrative review, you should be prepared to demonstrate that the Department's findings were in error.

You should also include any documentation or additional evidence that you wish to have reviewed as part of the administrative review. Your written request for administrative review should be addressed to, Randy May, Deputy Administrator, Division of Medicaid, 3232 Elder Street, PO Box 83720, Boise ID 83720-0036, Phone #: (208) 334-5747, Fax #: (208) 364-1811.

The rules and regulations governing the conduct of an administrative review are set forth at *IDAPA 16.05.03.300*. If you fail to timely request an administrative review, the Department's decision to impose remedies as set forth herein becomes final. Please note that issues, which are not raised at an administrative review, may not later be raised at higher level hearings (*IDAPA 16.05.03.301*).

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135090	A. BUILDING _____ B. WING _____	08/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUIS CARE AT SHAW MT	909 RESERVE ST BOISE, ID 83712

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F 000	INITIAL COMMENTS The following deficiencies were cited at the annual recertification survey at your facility. Surveyors conducting the annual survey were: Lory Dayley, RD, Team Coordinator Lisa Kaiser, RN Betty Vivian, RN, MSN Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	F 000	RECEIVED AUG 25 2006 DIV. OF MEDICAID The following POC is being submitted as required by federal regulation. The submission of this POC is not to be construed in any way as an admission by the facility of the deficiency nor the finding of fact.	
F 166 SS=D	483.10(f)(2) GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, it was determined the facility did not ensure residents' grievances were resolved. This had the potential to affect all eleven sample residents (#s 1 through #11) and all other residents or family members who could voice a grievance. Findings include:	F 166	**Corrective Action:** **1.** As Resident Council from Survey is anonymous, the facility cannot identify specific residents cited in this 2567, therefore, an audit will be completed, in person or via telephone, of all current residents/responsible parties to determine if they have any concerns or grievances that need resolution from the facility. **2.** Any findings from the audit will have a Concern/Grievance form completed with facility resolution of any identified concerns/grievances. **Identification:** All residents are identified as potentially being affected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 166	Continued From page 1 The survey team leader requested facility grievances at the entrance conference with facility administration on 7/24/06 at approximately 9:15 am. The facility provided the surveyors with forms from the past year that documented resident reports and facility action in relation to lost items. The facility did not provide completed grievance forms. On 7/26/06 at 9:30 am, during the group interview, two of the residents that attended the meeting voiced that they did not understand how to voice a grievance and the other ten residents did not comment on it at all. One resident stated she was missing a $20 bill. She said she had it in her purse before a hospital stay earlier in the year and when she returned the money was gone. The same resident stated she was missing some clothing. Another resident stated she was also missing some clothing. The DON, who was also the acting social service designee, was interviewed on 7/26/06 at 4:20 pm. She stated the lost item forms were all she could find; "that's all she [the previous social worker] had in the drawer." The Administrator was interviewed on 7/27/06 at 11:45 am regarding grievances. "...Obviously it fell through the cracks...we had a different social services person last year..." He stated that grievances were resolved in the facility's 24 hour stand up meetings and usually consisted of roommate issues. He stated grievances that were voiced during resident council meetings were resolved in the minutes of the meeting. He also indicated grievance documentation could be	F 166	**Systemic Changes:** **1.** All Concern/Grievance forms will be made available, in public area, accessible to all residents and families at all times. **2.** A Concern/Grievance Log book will be maintained per facility policy and procedure. **3.** All Concerns/Grievances will be reviewed during the facility's 24 Hour Report process and Care Conferences to ensure compliance. **4.** All staff to be inserviced regarding Concern/Grievance policy and procedure. **5.** Residents/Responsible Parties will be informed of the Concern/Grievance policy and procedure during audit, upon admission, during Resident Council, and during Quarterly Care Conferences. **Monitor:** Process to be monitored by Administrator during facility 24 Hour Report process and Quarterly QA meetings and by the Resident Care Manager/DNS during Quarterly Care Conferences.	9/2/2006

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F 166	Continued From page 2	F 166		

found in the nurses' notes in individual residents' charts. He stated he would provide the policy and pertinent information from the admission packet that addressed grievances. He said, "I'm comfortable that grievances are being addressed and resolved..."

The Administrator was again interviewed on 7/27/06 at approximately 3:00 pm regarding grievances. He stated he would look for completed grievances and continue to in-service staff as well as the residents in resident council regarding the grievance process. He stated grievance forms were in the chart room and the grievance process was in the Social Worker's manual. He indicated he would continue to look for grievances and stated, "...We moved offices, I'll look..."

The facility was unable to provide written documentation that resident grievances were addressed and resolved. Facility administrative staff in-serviced staff and members of the resident council on the grievance process and the location of grievance forms on 7/27/06. The facility provided the surveyors with a copy of the in-service and the accompanying policy and procedures.

On 7/27/06 at approximately 7:45 pm, a LN approached a surveyor to thank her for bringing the grievance process issue to the facility's attention. She indicated she had recently been in-serviced and stated, "...I had no idea we even had a process like that..."

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F 167 SS=C	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not have the most recent annual fire and life safety survey results readily accessible to 1 of 1 floors for residents. This could potentially effect 11 of 11 (#1 - 11) sampled residents, all other residents at the facility, and family members or personal representatives for the residents. The findings include: Idaho Department of Health & Welfare Informational Letter #2003-01, stated, "...I believe that when facilities are required at F167 to post a notice and make the most recent survey available to residents, this means the most recent initial survey, or the most recent recertification survey, or the most recent complaint survey. Included in the most recent initial survey and the most recent recertification survey, is the LSC [Life Safety Code]...With this federal guidance in mind, this agency will begin to check the survey posting with the expectation that the LSC survey will be posted along with the other required surveys. This will	F 167	**Corrective Action:** **1.** Fire and Life Safety Survey report posted with other Survey results. **2.** Staff and residents have been inserviced regarding the Survey results location. **Identification:** All resident are identified as possibly being affected. **Systemic Changes:** **1.** Facility staff will be inserviced regarding location and content of Survey results. **2.** Administrator to be notified if not in compliance. **Monitor** – Administrator to monitor monthly to ensure compliance	9/2/2006

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F 167	Continued From page 4 begin effective with the date of this letter..." The letter was dated 1/13/03. On 7/24/06 at 10:20 am, the survey book containing the most recent annual survey, was observed in a wall mounted cubby. The fire and life safety annual survey results were not in this book. The DNS was asked at this time, why the fire and life safety survey results were not in with the other surveys. The DNS looked in the book and acknowledged that the fire and life safety results were not in the book and indicated that they should have been. At this time the Adminstrator joined in on the conversation and indicated that he would get a copy of it and put it in the survey book.	F 167		

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F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 225	**Corrective Action:** **1.** Resident #4 was discharged from Marquis Care. Unable to complete investigation. **2.** Resident #2 toe nails have resolved. Addendum to investigation to be completed. Resident and staff to be interviewed regarding the incident. **Identification:** All residents are identified as possibly being affected. **Systemic Changes:** **1.** Staff to be inserviced regarding incident reporting, investigation of incident and accidents, abuse policy and procedure, and injuries of unknown origin. **2.** Licensed Nurse staff to be inserviced regarding incident reporting documentation requirements , including staff and resident interviews, and completion of abuse/neglect investigations. **Monitor:** **1.** All Accident and Incident reports to be monitored by the Administrator during facility's 24 Hour Report process for completion of documentation. **2.** Accidents and incidents to be reviewed by QA Committee monthly.	9/2/2006

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F 225	Continued From page 6 by: Based on record review and staff interview, it was determined the facility did not thoroughly investigate injuries of unknown origin to rule out the possibility of abuse. This was true for 2 of 11 sampled residents (#2 & 4). Findings include: 1. Resident #2 was originally admitted to the facility on 7/31/03 and readmitted on 2/25/06 with diagnoses including Multiple Sclerosis, arthritis, hypertension, and depression. An "Accident or Incident Report" dated 6/8/06, documented the resident had sustained an injury, specifically, "Toe nail pulled up/off 3 [rd] & 4th toes LLE [left lower extremity]." The report documented the location of the incident as the "Dining Room" and included the names of 3 witnesses. The report documented via a checkmark that the resident had been interviewed and environmental factors had been addressed. The one page report was signed by 5 staff members, including the DON and Administrator. Attached to the report was a copy of "Interdisciplinary Progress Notes." The progress notes documented the following: *6/8/06 2:00 pm - "Pt [patient] c/o [complained of] foot pain. NA [nurse aide] student found blood on pt [left] sock. Pt awake & oriented. Nursing found [left] 3[rd] & 4[th] toe nails to be pulled up to Quick. 3rd toe nail cut as not to pull any further. Unknown origin of incident, client care manager notified, fax sent to MD..." *6/906 11:30 am - "F/U [follow up] on toenail injury of 6/8/04 [year documented incorrectly].	F 225		

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F 225	Continued From page 7 [Resident #2] is alert & oriented. She is non-ambulatory et [and] unable to bear wt. [weight] r/t [relating to] Multiple Sclerosis. She is transferred [sic] [with] mechanical lift. Her wt [weight] is 248 # [pounds]. She has skin issues d/t [due to] her wt et size so is on an air mattress [with] full side rails. She completed Cipro 500 mg [milligrams] po [by mouth] BID [two times per day] per [name of physician] in preparation for suprapubic catheter place[ment] & UTI [urinary tract infection]. Catheter was placed 6/6/06 et is on Cipro for 3 days post-op[eratively]. [Resident #2] is unable to move her lower extremities. This Nurse had been in room to [check] blister to [left] knee prior to accident [with] toenail. Left foot was solidly against lateral side of foot pedal. She c/o pain in foot so I slowly moved foot away from pedal et [unable to read next 2 words] foot immediately returned to the same position. I [checked] rest of her body to see if she could be repositioned in w/c [wheelchair] but she was tight in chair. Hips were right against side of w/c [with] no room to spare. Has blister on inner thigh et in past had blisters on bilateral hips. CNA have no idea how toes got injured. I will get aides to have PT/OT [Physical Therapy/Occupational Therapy] eval[uation] for a larger w/c." The investigation report was missing key information. There were no documented interviews from staff or the listed witnesses regarding the condition of the resident's toes prior to the note dated 6/8/06 at 2:00 pm. It did not indicate who provided cares for the resident and/or who may have seen her feet prior to the incident. It did not address the condition of the resident's foot when she was dressed earlier in the day.	F 225		

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F 225	Continued From page 8 There was no documented interview from the resident who was identified as "alert and oriented" on 6/9/06 and was able to speak for herself as observed by the surveyor during the survey. The report did not address what, if any, other environmental factors were investigated. The nursing notes documenting the wheelchair incident were unclear and it was difficult to ascertain if the injury occurred in the wheelchair at that time or sometime before. It was unclear as to when the wheelchair incident occurred as the nursing note was written the day after the injury was discovered. An interview was conducted with the DON and 3 Resident Care Managers on 7/27/06 at 12:45 regarding the resident's injury and subsequent investigation. The DON stated that when investigating an incident such as this, staff on shift as well as the resident are interviewed. She stated, "It's unfortunate this didn't come across [in the report]." The DON was unaware of the information required for an investigation in order to rule out abuse or neglect. She was unaware of how to access informational letters available on the internet to assist her in meeting the requirements of this regulation. The resident sustained an injury of unknown origin that was not thoroughly investigated to rule out abuse. The report did not contain witness or resident statements or interviews. Administrative staff signed the report without conclusive evidence that abuse did not occur. 2. Resident #4 was admitted to the facility on	F 225		

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F 225	Continued From page 9	F 225		

7/29/04 with the diagnoses of Multiple Sclerosis, dementia, neuropathy, restless leg syndrome, chronic pain, and urinary retention.

On 4/25/06 an Accident or Incident Report documented the resident had received "2 open areas on R [right] buttocks". This report indicated the incident happened at 4:30 pm in room 205 on 4/20/06. The form documented that the physician and responsible party was notified, alert charting was started and that treatment was given.

On 7/26/06 at 9:05 am, the DNS was interviewed. She indicated that all investigations are documented in the nursing notes and that she would get that information for the surveyor. The surveyor referred the DNS to informational letter #2005-1 which relates to the investigation of potential abuse. The DNS indicated that she had never seen this letter before or how to retrieve it. On 7/27/06 at 10:50 am, the DNS provided the nursing note and indicated that was all there was for the investigation.

The nursing note for 4/25/06 at 2:00 pm documented, "Due to skin breakdown res[ident] placed on full air mattress as she was previously on an air mattress overlay. Res[ident] continues [with] last up [and] first down r/t [related to] skin issues unless she refuses. Res[ident] also being treated for UTI [urinary tract infection] which in the past has [increased] her behaviors [with] hx [history] of care refused. MD [and] family notified of POC [plan of care] [changes]. Full rails [times] 2 to maintain air mattress integrity."

This investigation did not include interviews with staff who had worked with her to determine how

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F 225	Continued From page 10 the two open areas occurred. It could not be determined that neglect or abuse had been ruled out. On 7/27/06 at 1:10 pm, the DON was interviewed and acknowledged that the above investigation was not complete and thorough.	F 225		
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility did not appropriately screen a new employee for a history of abuse or neglect. One of 5 random new employee files were reviewed. Employee #A did not have a fingerprint based background search completed through the appropriate government agency. Findings include: The facility provided the surveyors with 5 random new employee records which included license verification and background check information. Employee #A's file documented he was hired by the facility effective 4/11/06. The employee's record also contained documentation from the State Police Bureau of Criminal Identification, signed 4/13/06, that documented the following: "Results of Non-Certified Record Search" and "No Record Found." Information contained on the	F 226	**Corrective Action:** Employee identified during Survey as needing to complete the fingerprint-based criminal background check, is a Dietary Aide, and has begun the process and will be working with direct supervision until background check can be completed. **Identification:** All residents are identified as possibly being affected. An audit of all employee files has been completed to ensure all criminal background checks have been completed. **Systemic Changes:** Human Resources Director has been inserviced regarding the requirement to complete criminal background checks on all potential new employees, and will ensure that no employee in direct resident care is without direct supervision until criminal background check is completed. **Monitor :** Administrator and Human Resources Director will monitor process for compliance. Process to be reviewed by QA Committee monthly.	9/2/2006

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F 226	Continued From page 11 bottom portion of the form documented, "Criminal history record information furnished as a result of a non-fingerprint based computerized search is based solely on a search of identifiers provided in the request. Be aware it is not uncommon for criminal offenders to use alias names and false dates of birth, which would adversely affect the completeness and accuracy of a non-fingerprint based search..." The facility's Administrator was interviewed on 7/27/06 at 8:31 pm regarding this employee's criminal background check. He stated, "...that's all there was in the file..." The facility did not ensure a thorough background check was completed on an employee who was hired effective 4/11/06. Appropriate background checks were to be completed through the state's Department of Health and Welfare and required the employee to submit fingerprints to thoroughly research the existence of a criminal history.	F 226		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined the facility did not ensure each resident's dignity was maintained when staff failed to pull the privacy curtain and close blinds on a window to the	F 241	**Corrective Action:** Resident #10's care plan has been revised to include maintenance of privacy and dignity with cares and services. (ie. Incontinent care, transfers, wound care, and other ADL care and services.) **Identification:** All residents are identified as potentially being affected. Continued on p. 13	

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F 241	Continued From page 12 outside during the provision of personal care. This was true for 1 of 11 sampled residents (#10). Findings include: Resident #10 was admitted to the facility on 6/24/06 with the diagnoses of dementia and cardiovascular disease. The resident's admission MDS, dated 7/3/06, documented the resident was severely cognitively impaired and was totally dependent on one or two staff for all activities of daily living. On 7/28/06 at 9:25 am, resident #10 was assisted to bed by 2 CNAs. Both CNAs transferred the resident to her bed using a Hoyer type mechanical lift. At this time, the resident's roommate was sitting in her wheelchair to the left of resident #10's bed. The CNAs transferred the resident to the bed using a lift. A window to the right of the resident's bed had the blinds drawn and the courtyard/parking lot was visible through the window. The CNA lifted the resident's gown to her abdomen exposing the resident's adult briefs. The resident was turned to the right with her back to the window. The CNA then checked the resident for incontinence. The LN came into the room at that time to change the resident's dressing to a pressure sore on the sacral area. The resident was soiled with feces. The CNA and the LN provided care to remove the feces, cleansed the area and changed the dressing with the blinds open. The privacy curtain between the resident and her roommate was only partially closed. The resident was exposed during personal care to the roommate and potentially to anyone passing by the resident's window. The staff did	F 241	**Systemic Changes:** **1.** All staff will be inserviced regarding resident rights surrounding privacy and dignity during cares and services. **2.** The facility will complete random resident care and environmental rounds daily for 4 weeks and then weekly thereafter. **3.** Audits will be reviewed with facility Monthly QA review to identify trends to ensure compliance. **Monitor:** DNS and Administrator to monitor audits.	9/2/2006

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F 241	Continued From page 13 not protect the resident's privacy and dignity when they neglected to pull the privacy curtain and shut the blinds.	F 241		
F 246 SS=E	483.15(e)(1) ACCOMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined the facility did not ensure that residents' needs were accommodated. One random resident (#13) was observed to eat his meals at a dining room table that was too high. It was also determined that 3 of 11 (#2, 3, & 5) sampled residents and 2 random residents (#16 & 17) did not have a call light placed within reach. The findings include: Call lights: 1. Resident #5 was admitted to the facility on 8/25/05 with the diagnoses of dementia, depression, osteoporosis, psychosis, and chronic back pain. On 7/26/06 at 8:00 am, resident #5 was observed to be sitting in his recliner sleeping. The resident's call light was observed to be draped over the resident's bed approximately four feet away from the resident's recliner. Ten minutes later a NA	F 246	**Corrective Action:** **1.** Resident #13 has had an evaluation from Occupational Therapy and a table has been adapted to meet this resident's needs. **2.** Residents #2, 3, 5, 16, and 17 have been added to daily environmental audits to ensure call lights are within reach. **3.** Resident #16 is independent and does not utilize call light and has a history of removing call light from bed because she does not want it there. An alternative will be offered and the care plan updated to reflect resident's request. **Identification:** All residents are identified as potentially being affected. **Systemic Changes:** **1.** Facility staff inserviced regarding call light placement. **2.** Environmental rounds to be completed daily for 4 weeks, then weekly thereafter and ongoing. **3.** Audits will be reviewed monthly with facility QA to identify trends and to ensure compliance. **Monitor:** DNS and Administrator to monitor process.	9/2/2006

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F 246	Continued From page 14 enters the resident's room and the surveyor asked if the resident should have his call light by him and the NA indicated that he should have had the call light within reach. Before the NA left the room she placed the call light on the residents lap. 2. Resident #3 was admitted on 4/28/06 with diagnoses which included CVA [stroke] hematoma of left leg, sacral stenosis, and dementia. On 7/25/06 at 8:35 am, the surveyor tested the call light in the resident's room. The call light did not work and the Administrator was notified of the malfunction. The Administrator and Maintenance Man immediately returned with a new call light and cord and connected it to the wall plug. The call light was tested and found to be in working order. On 7/25/06 at 12:04 pm, the resident was observed in bed. The resident was sleeping in a low bed and her call light was tucked in a basket approximately 3 to 4 feet above her head. On 7/26/06 at 12:10 pm, a Resident Care Manager (RCM) was interviewed regarding the resident. The RCM stated the resident was not cognitively aware enough to use her call light "but it should always be in reach..." 3. During the initial facility on 7/24/06 at 9:14 am, random resident #16 was found to have no call light available at her bedside. There was a call light and cord laying on the foot of the other bed in the room. The resident was in bed resting at the time of the observation.	F 246		

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F 246	Continued From page 15 On 7/24/06 at 2:00 pm the resident's room was observed for a 2nd time. There was no call light at the resident's bedside and a call light and cord remained on the foot of the other bed in the room. The resident was in bed resting at the time of the observation. The DON was notified and she immediately had the maintenance man come in to hook up the call light for the resident. She stated,"She [the resident] pulls it out all the time." 4. There were similar findings for resident # 2 and random resident #17. Meal positioning: 1. On 7/25/06 at 8:30 am and on 7/26/06 at 8:40 am random resident #13 was observed to be eating his breakfast in the Sun Lounge dining room, while sitting in his wheel chair. The resident's wheel chair arm rests went under the dining room table with approximately a 3 inch gap between the wheel chair arm rests and the table. The top of the table reached the resident mid-chest. The resident was observed struggling to lift his elbows and arms up high enough to get the food on his utensil. On 7/26/06 at 8:50 am, the DON was made aware of this observation and indicated that she would get Occupational Therapy to evaluate the resident. On 7/27/06 at 3:50 pm, the Occupational Therapist provided the surveyor with her evaluation and indicated that the resident benefited from sitting at a table that was shorter and that the residents food intake increased when	F 246		

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F 246	Continued From page 16 he was seated at a shorter table.	F 246		
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review it was determined the facility did not ensure medically-related social services related to discharge planning was provided for 2 of 12 sample residents (#'s1 and 10) Findings include: 1. Resident #10 was admitted to the facility on 6/24/06 with status post cerebrovascular accident (CVA) and dementia. The resident's admission MDS, dated 7/3/06, documented the resident as severely cognitively impaired and required total assistance for all ADL's. The following information was documented in nurse progress notes: a) 6/30/06, Attempted to call daughter related to room, no answer. b) 7/11/06, Daughter contacted related to skin breakdown, answering machine.	F 250	**Corrective Action:** **1.** Resident #10 remains in the facility under hospice care. A Social Service Consultant will conduct a review of resident's discharge plan and hospice care. Discharge to home with hospice orders were received from the primary physician, but no specific date is planned at current for discharge pending social service follow-up. A Care conference will be held with resident's daughter (POA), hospice, and facility Interdisciplinary Team (IDT) to determine safe discharge goals. **2.** Resident #1 remains in the facility. A Social Service Consultant will conduct a review of resident's discharge plan. A Care Conference will be held with the resident, family, IDT, and interpreter if necessary to discuss discharge planning. A list of all facilities in the Nampa/Caldwell area will be obtained and offered to the resident as options. Requests for consideration of admission will be made to each of the facilities that have not already denied admission **3.** With respect to Resident #1's request for a private phone, the facility will discuss with the resident the options available. If the fee is above the resident's monthly trust allotment, the facility will absorb the difference. **Identification:** All residents are identified as potentially being affected. Continued on p. 18	

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F 250	Continued From page 17 c) 7/19/06, Phone call from [home health/hospice agency name], requesting medication sheets for discharge tomorrow. Facility does not have a discharge order. Called the daughter, she stated she cannot afford to keep her mother there ... and will be taking her mother home tomorrow. d) 7/20/06,[home health/hospice agency name] called, not in agreement with discharge. There was no social service plan or information related to Hospice respite or information related to the problems with discharge. On 7/28/06 at 9:25 am a LN stated the resident was to be going home but she did not know when as the daughter had not come in to get the resident. On 7/28/06 at 10:15 am the, DON was interviewed about the pending discharge. She stated that although she was the social service designee she had not been involved with these issues related to this resident. On 7/28/06 at 10:30 am, the Unit Manager LN was interviewed. She stated that she had some information from outside sources indicating the environment may not be safe for the resident when she went home. She also stated it was her understanding the daughter had a heart attack soon after the resident was admitted to the facility. The LN stated she and other nurses documented information related to resident's social problems but did not necessarily address the problems. The facility did not coordinate services in planning	F 250	**Systemic Changes:** **1.** An audit of all discharge plans will be made on all current residents to ensure discharge needs, plans, and services are met. **2.** Social Service Consultant will review any behaviors associated with discharge wants/needs and intervene as applicable on all current residents. **3.** All discharge planning will be documented in the resident's clinical record. **4.** IDT will review discharge plans during facility 24 Hour Report process prior to any non-emergent discharge and at quarterly Care Conferences. **5.** The facility is currently interviewing for a full-time social service director and will hire and train for this position. **6.** All Licensed Nurse staff will be inserviced regarding discharge planning documentation and safe community discharge process as well as care plan updating, dating, and initialing. **7.** All care plans for current residents will be reviewed by social Service Consultant and will be updated as needed, dated, and initialed. **Monitor:** Administrator will monitor discharge planning weekly for four weeks and quarterly thereafter. All discharge plans and discharge process will be reviewed through facility QA process.	9/2/2006

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F 250	Continued From page 18 the resident's discharge to a safe environment. 2. Resident # 1 was originally admitted to the facility on 10/19/05 and most recently readmitted on 5/23/06 with diagnoses including Quadriplegia, decubitus ulcer, osteomyelitis, pancytopenia, cirrhosis, diabetes mellitus 2, Methicillin resistant Staphylococcus Aureus [MRSA], depression, chronic anemia, and chronic leukopenia. An MDS, dated 6/5/06, documented the resident was moderately impaired cognitively and was totally dependent on staff for most ADLs. The MDS documented the resident's mood had deteriorated since the last assessment. An "Assessment Summary" dated 6/5/06, documented the following: *"Delirium: Res[ident] triggered RAP [secondary to] decision making. Res refusing meals & meds [medications] at times. Res to ER [emergency room] on 6/2 for eval[uation] [secondary to] refusal of meds & meals. Since trip to ER res has resumed taking meds & eating meals. Res also allowing cares. Res had a [change] in mood [secondary to] desire to move to facility in [names of 2 towns] are to be closer to family. So far 2 facilities have declined to take res." *"Cognitive: ...Res desires placement in facility closer to family and has past refused meds, meals & cares. Res now eating & taking meds & allowing cares. Res sister [first name] is looking for placement in [name of 2 towns] & has been provided [with] names & phone # [numbers] for those facilities..."	F 250		

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*"Psychosocial: ...He remains able to establish his own goals. Resident has family living in the [name of towns] area. Lately he has expressed interest in moving to a fac. [facility] closer to his family. Various facilities [name of 2 facilities] have declined admission to their facility..."

*"Mood Behav[ior]: Resident does have 2 mood/behav [behavior] indicators on this MDS. These may be d/t [due to] resident's personal frustration [with] wanting to move and being denied admission by 2 facilities at this time. Resident's way of expressing his frustration [with] his circumstances was through refusal of care & meds. Family is continuing to pursue placement in [name of towns] area..."

A care plan that was not dated, addressed the placement issue and related behaviors in problem #6 as follows: "Behavior/Emotional Changes R/T [related to]: Other: Self isolation, [increased] health complaints, making sexual comments, refusal of cares. Short Term Goal: Will turn q [every] 2 [hours] this assessment period. Approach: Resident specific interventions 1:1 [one to one] reassurance, offer activities, involve family, depression meds per MD order. 1) Explain necessity of turning (pressure areas). 2) Report refusal to LN."

The "Discharge Plan" portion of the care plan did not address the resident's desire to move to another facility. The discharge plan was documented as "Long Term Care" and there were no short term goals or approaches documented.

"Interdisciplinary Progress Notes" documented the following:

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F 250	Continued From page 20 *5/30/06 at 4:10 pm - "social services was asked per [name of family member] to assist resident in transferring to [name of town] nursing home..." *5/31/06 @ 1:30 pm - "social services faxed medical info[rmation] to [name] at [name of 1st facility] per resident's choice/request." *6/2/06 @ 12:00 pm - "Re[ported] by LPN that res is refusing food, meds et [and] cares et states 'let me die.' Asked res what we could do to help et he states 'nothing.' RCM [Resident Care Manager] to notify Dr. [name] of negative statements et to provide direction." *6/2/06 @ 3:20 pm - "social services notified of resident refusing all treatment interventions. Family was notified by DNS and sister came to facility. Per resident he had [an increase] in sadness [after] [name of another facility] refused him in their facility. RCM contacted MD and MD ordered ER [emergency room] eval[uation]. Family and resident plan to address their desire to have resident moved to [name of town] fac[ility] (closer to family) [with] ER MD. [unable to read word] social services monitor outcome." *6/5/06 @ 11:15 am - "Social services received phone call from [name] at [name of 2nd facility]. Family requesting consideration for transfer. Medical info. faxed to [name] per her request." *6/5/06 @ 12:30 pm - "...Family will be contacting [name 2nd facility]. Social services to follow." *6/30/06 1:30 pm - "Discussed possible admission to [name of 3rd facility] [with] SS	F 250		

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F 250	Continued From page 21 [Social Services] [name] per [resident #1's] sister request. Info faxed to [name of 3rd facility]." *7/6/06 at 1:50 pm - "Call placed to [name of 4th facility] & message left for [name] Admission Coordinator regarding placement of [resident #1] to [name of town] area." *7/6/06 at 2:00 pm - "H & P [history and physical] faxed to [name] at [name of 4th facility]." After 7/6/06 there was no further documentation regarding placement of the resident in a facility closer to his family. An interview was conducted with the resident on 7/27/06 at 8:50 am. The resident stated he wanted to move closer to his family in the [name of towns] area. He thought his sister was working with the DON regarding this issue. He stated he was anxious to get moved as his sister could not visit him as often as he would like and he gets lonely. An interview was conducted with the DON, who was the social service designee at the time of the survey, and 3 Resident Care Managers (RCMs) on 7/27/06 at 11:55 am regarding the resident's potential transfer to another facility. The DON stated, "He wants to go to the ER all the time because he wants to move to the [name of 2 towns] area." The DON and RCMs stated they have worked with different facilities and all have declined to admit the resident. They stated the resident's children were not able to visit him at the present time and the resident was not able to have a private phone in his room because he did not have the money to pay for it.	F 250		

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F 250	Continued From page 22 The facility failed to ensure a resident received ongoing social service assistance to facilitate a transfer to a facility closer to his family. The resident experienced loneliness and frustration and in return, occasionally exhibited behaviors such as refusing cares and medications.	F 250		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined the facility did not ensure a tub room had working hot water and shower rooms had mildew-free grout. This was true of 1 of 1 tub rooms and 4 of 4 shower rooms. This had the potential to affect all residents in the facility. Findings include: 1. On 7/26/06 at 3:16 pm, the maintenance man conducted a walk through environmental inspection with a surveyor. The maintenance man revealed that the tub room on the short 300 hall did not have hot water. He stated he had just learned of this and as far as he knew, the hot water had been out of commission for approximately 2 months. The maintenance man was fairly new to the facility and due to an apparent lack of communication, learned of the hot water issue during the survey. He was planning on looking into that issue as well. This was the only tub room in the facility so residents	F 253	**Corrective Action:** **1.** Tub room will be repaired for hot water. **2.** All four shower rooms have been either cleaned of mildew or re-grouted. **Identification:** All residents are identified as potentially being affected. **Systemic Changes:** **1.** Maintenance Supervisor will be inserviced on completion of environmental rounds. **2.** Maintenance will complete weekly environmental audits of shower rooms and tub room to ensure compliance for cleanliness and water temperatures. **Monitor:** Administrator to monitor audits weekly and at QA review	9/2/2006

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F 253	Continued From page 23 who would like a bath only had the option of showering. 2. During the environmental inspection it was noted that all four of the shower rooms inspected (2 on 200 hall, 1 on 300 hall, and 1 on 100 hall) had mildewed grout in the shower stalls and along some of the walls. The surveyor and the maintenance man discussed the mildew issue and the maintenance man stated he would take care of it. The facility did not ensure the tub room had working hot water and that grout in the shower rooms was clean.	F 253		

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F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review it was determined the facility did not ensure that an accurate and comprehensive assessment was completed for 1 of 11 sample	F 272	**Corrective Action:** Resident #3 will have comprehensive assessment completed to reflect the resident more accurately in the Resident Assessment Protocols (RAPS). Care plan will be updated to reflect resident's current and accurate status also. **Identification:** All residents are identified as potentially being affected. **Systemic Changes:** All IDT members will be inserviced by Nurse Consultant regarding MDS process, to include RAP and care plan completion, and dating and initialing of care plan updates. **Monitor:** **1.** DNS will monitor MDS reports for accuracy with the IDT weekly. **2.** Health Information Coordinator (HIC) will audit MDS reports weekly for completion based on MDS schedule, care plan dating and initialing for review date, updates and goal dates. **3.** Administrator /DNS to monitor MDS for timely completion and accuracy weekly and in QA review.	9/2/2006

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residents (#3) who lost 18 pounds of weight the first month of her admission. It was determined RAPs were not adequately used to assess the MDS triggered areas. Findings include:

The CMS's RAI Version 2.0 Manual - Ch 4 procedures for completing RAP's indicate the following: "The MDS identifies actual or potential problems areas. The RAPs provide further assessment of the triggered areas; they help staff to look for causal or confounding factors (some of which may be reversible). Use the RAPs to analyze assessments."

Resident #3 was admitted on 4/28/06 with diagnoses which included CVA [stroke], hematoma of left leg, sacral stenosis, dementia and history of peptic ulcer. Upon admission, the resident's weight was documented as 132 (pounds) and she was 5' 1-1/2" inches tall.

The admission MDS, dated 5/9/06, indicated the resident was severely cognitively impaired and dependent for all ADL's. The resident required extensive assistance of one staff member to eat. The "Nutritional Status RAP Module" dated 5/11/06, documented, the resident required extensive assistance eating. The nursing summary RAP, documented, "Res-[ident] at times is dependent for eating and will not feed herself. Needs assistance and cuing to eat and drink." The behavior RAP indicated the resident was receiving pain medication and psychoactive medication to control behaviors such as resisting cares. The behaviors may have been due to pain. The sedative effect of these drugs were not considered in the assessment as it related to the resident's nutritional status. The resident's vision,

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F 272	Continued From page 26 cataracts and glaucoma, were not associated with the resident's ability to feed herself until after the weight loss and occupational therapy saw the resident and identified the problem. Failure to thoroughly assess the resident initially and proceed to a care plan for these potential problems resulted in weight loss during the first month of the resident's stay in the facility.	F 272		
F 279 SS=E	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record	F279	**Corrective Action:** Residents #1,2,3,4,5,6,7,8,and 9 will all have their care plans reviewed for accuracy, measurable objectives for identified problems, approaches, and correct dating and initialing at care plan completion. **Identification:** All residents are identified as potentially being affected. **Systemic Changes:** **1.** IDT will be inserviced by Nurse Consultant regarding MDS process and care plan completion for accuracy, dating , and initialing. **2.** A Care Plan Review sheet will be added to each clinical record for IDT signatures and dating with admission/MDS process completion. **3.** All resident care plans will be audited for accurate completion. **4.** Licensed Nurse staff to be inserviced regarding accurate documented standards with review of documentation policy and procedures, to include appropriate manner in discontinuing content in resident clinical record. **Monitor:** **1.** HIC will audit care plans for completion, dates, and initials weekly per MDS schedule. **2.** DNS to monitor care plans for accuracy with IDT weekly per MDS schedule,	9/2/2006

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review, it was determined the facility did not ensure care plans for 9 of 11 sample residents (#1, 2, 3, 4, 5, 6, 7, 8, and 9) were developed to meet their identified needs based on a comprehensive assessment of the individuals and included measurable objectives and timetables. Findings include:

1. Resident #4 was admitted to the facility on 7/29/04 with the diagnoses of Multiple Sclerosis, dementia, neuropathy, restless leg syndrome, chronic pain, and urinary retention.

The care plan, not dated, did not have measurable objectives for the following identified problems: Urinary tract infections, nutritional risk, Behavior/emotional changes, cognitive/communication, coping with new environment, and combative with cares.

2. Resident #5 was admitted to the facility on 8/25/05 with the diagnoses of dementia, depression, osteoporosis, psychosis, and chronic back pain.

The care plan, not dated, did not have measurable objectives for the following identified problems: nutritional risk.

3. Resident #7 was admitted to the facility on 7/21/06 with the diagnoses of hypothyroidism, femur fracture, chronic aspiration, aspiration pneumonia, and squamous cell tongue cancer.

The care plan, not dated, did not have measurable objectives for the following identified problems: Foley catheter, fall risk, nutrition risk, respiratory status, pain, and coping to a new

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F 279	Continued From page 28 environment. 4. Resident #1 was originally admitted to the facility on 10/19/05 and most recently readmitted on 5/23/06 with diagnoses including Quadriplegia, decubitus ulcer, osteomyelitis, pancytopenia, cirrhosis, diabetes mellitus 2, neurogenic bladder, Methicillin Resistant Staphylococcus Aureus [MRSA], depression, chronic anemia, and chronic leukopenia. The care plan, not dated, did not have goal dates for the following identified problems: "MRSA, Nutritionally at Risk R/T [related to], Behavior /Emotional Changes R/T, Change In Daily Activity Routine, Coping To New Environment" and "Discharge Plans". The temporary care plan had a problem, dated 6/27/06, "BUE pn [bilateral upper extremity pain]" with a goal of "pn will be [decreased]. No goal date was documented for this problem. The problems "Coping To New Environment" and "Discharge Plans" did not have documented goals. The problem regarding discharge planning did not have any identified approaches. 5. There were similar findings for residents #2, 3, 6, 8, and 9.	F 279		

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F 280 SS=E	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, it was determined the facility did not ensure care plans were updated to reflect the current status of each resident. This was true for 4 of 11 sampled residents (#'s 1, 2, 3, and 5). Findings include: 1. Resident #1 was originally admitted to the facility on 10/19/05 and most recently readmitted on 5/23/06 with diagnoses including Quadriplegia, decubitus ulcer, osteomyelitis, pancytopenia, cirrhosis, diabetes mellitus 2, Methicillin Resistant Staphylococcus Aureus [MRSA], depression, neurogenic bladder, chronic anemia, and chronic leukopenia.	F 280	**Corrective Action:** Residents #1,2,3, and 5 will all have their care plans reviewed for accuracy, measurable objectives for identified problems, approaches, and correct dating and initialing at care plan completion. **Identification:** All residents are identified as potentially being affected. **Systemic Changes:** **1.** IDT will be inserviced by Nurse Consultant regarding MDS process and care plan completion for accuracy, dating , and initialing. **2.** A Care Plan Review sheet will be added to each clinical record for IDT signatures and dating with admission/MDS process completion. **3.** All resident care plans will be audited for accurate completion. **4.** Licensed Nurse staff to be inserviced regarding accurate documented standards with review of documentation policy and procedures, to include appropriate manner in discontinuing content in resident clinical record. **Monitor:** **1.** HIC will audit care plans for completion, dates, and initials weekly per MDS schedule. **2.** DNS to monitor care plans for accuracy with IDT weekly per MDS schedule.	9/2/2006

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The resident's pre-printed care plan was not dated, noted an admission date of 5/2306 and included several handwritten additions of problems, goals, and approaches. There was no way to determine when these handwritten items were added to the care plan as none of them were dated. On problem #1 "ADL/REHAB" there was an approach documented "No draw sheet under Res[ident] in bed. Put foot of bed [up] first then head of bed [up] to reduce shearing." Another approach under problem #1 that was handwritten and not dated was "[Bilateral] hand splints on [after] lunch, off [before] dinner." Also included in problem #1 was "MRSA" and the short term goal for this problem was documented as "Resolve." The approaches for this problem were documented as "Contact precautions, Isolation, No roommate, Rx [prescription] per MD." At the time of the survey, the resident was no longer on isolation.

The care plan included undated additions in problems #'s 2, 6, and 7. It was difficult to ascertain when specific problems and approaches/interventions began. Problem #2 "Skin Integrity/Edema" included documentation of a bruise and a skin tear that were no longer a problem for the resident.

The diagnosis of diabetes mellitus 2 was not care planned.

The facility did not ensure the resident's care plan was updated to reflect his current status and the treatments that were in place.

2. Resident #2 was originally admitted to the

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F 280	Continued From page 31 facility on 7/31/03 and readmitted on 2/25/06 with diagnoses including Multiple Sclerosis (MS), arthritis, hypertension, urinary retention and depression. The care plan was not dated but noted an admission date of 2/24/06. The pre-printed care plan contained many handwritten additions of problems, goals, and approaches that were not dated. Some examples include problem #1 "ADL/REHAB" and specifically "Unable to smoke safely alone [secondary] to MS." The goal for this identified problem was "Staff to assist [with] smoking." There were 3 documented approaches included to address this issue. According to nursing notes, the resident had quit smoking on 7/4/06. In problem #6 "Behavior/Emotional Changes R/T [related to]" included an undated problem documented as "Smoking Cessation." There was no documented goal for this specific problem and the undated approaches included: "1) Res[ident] requests that she be taken to her room if she becomes upset et [and] turn on [name of singer]...2) Nicotine patch." The facility did not ensure the resident's care plan was updated to reflect her current status and treatments that were in place. 2. Resident #5 was admitted to the facility on 8/25/05 with the diagnoses of dementia, depression, osteoporosis, psychosis, and chronic back pain. Resident #5's July recapitulation orders	F 280		

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documented that the resident had a merry walker for mobility.

Resident #5's most recent care plan dated with a goal date of 10/12/06 indicated that the resident had a merry walker for mobility and positioning. The care plan did not identify when the resident was to be released from the merry walker.

On 7/25/06 at 9:10 am, the DNS was aware that the release of the resident's merry walker was not care planned. She indicated that the resident was not able to release himself from the merry walker and that it should have been care planned.

On 7/26/06 at 7:10 am, the DNS provided an updated care plan addressing the resident's Merry Walker.

4. There were similar findings for resident #3.

An interview was conducted on 7/26/06 at 7:07 am with the Administrator regarding care plans. He stated, "...we in-serviced all staff last noc..." He stated information provided in the in-service included dating and initialing changes to care plans. The Administrator provided the surveyors with a copy of an in-service, dated 7/25/06, given by the corporation's nurse consultant. The content of the in-service included information regarding dating additions and/or deletions to a resident's care plan.

An interview was conducted on 7/27/06 at 11:55 am with the DON and 3 Resident Care Managers (RCM). They explained that resident care plans were reviewed every morning. The DON stated, "Every morning we do stand up meetings and

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F 280	Continued From page 33 update care plans...now we're dating them..." The DON stated that when an issue was resolved or discontinued, it was lined through with a yellow highlighter pen.	F 280		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility did not ensure nursing services provided met professional standards of practice. Two medication errors were observed during medication pass and one medication error occurred prior to the survey when an agency LN and facility LN incorrectly identified a resident. This affected 3 of 11 sample residents (#'s 1, 2 & 3). Findings include: 2. Resident #2 was originally admitted to the facility on 7/31/03 and readmitted on 2/25/06 with diagnoses including Multiple Sclerosis, urinary retention, history of urinary tract infections and pyelonephritis, arthritis, hypertension, and depression. During the observation of the medication pass on 7/25/06 at approximately 7:36 am, an LN was observed to medicate resident #2 for pain. The LN was observed to go to the Pyxis and withdraw one tablet of Norco. The LN was observed to sign off the medication on the MAR and to administer	F281	**Corrective Action:** **1.** Residents #1 and 2 will have medication pass audited to ensure medications given as ordered. Medication Error report has been completed. **2.** Resident #3 was corrected at the time of the incident and the facility assured alternative identification (photo identification in Medication Administration Record) is present on residents who refuse to wear armband. **Identification:** All residents are identified as potentially being affected. **Systemic Changes:** **1.** Licensed Nurse staff will be inserviced regarding accurate medication pass, medication order reconciliation with pass, and documentation as well as facility policy on "pour-pass-document". **2.** All residents have been audited to ensure identification is in place either via armband and/or photo identification. **3.** Resident Care Mangers (RCM) to audit via Admission Checklist, that all resident identifiers are in place (armband, photo ID, and door nameplate). Care plan will be updated with any refusals to wear armband or to have photo taken. **4.** All Charge Nurses will have a medication pass audit inservice completed to ensure accurate medication pass process. Continued on p. 35	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUIS CARE AT SHAW MT	909 RESERVE ST BOISE, ID 83712

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F 281	Continued From page 34 one tablet of Norco to the resident immediately after documenting it. Upon reconciling the resident's medications, the surveyor discovered a discrepancy between the physician's order and the medication administered to the resident. The physician's RECAP, dated 7/06, documented an order dated 4/27/06 for "Hydrocodone/APAP 5/325 (Norco) 2 TABS [tablets] PO [by mouth] BID [two times per day]..." The resident's MAR, dated 7/06, contained the LN's initials at 8:00 am documenting 2 tablets of Norco had been given. The facility was informed of this error in the afternoon of 7/27/06. At approximately 3:00 pm, a Resident Care Manager (RCM) notified the surveyor that the LN had been questioned regarding the error and she was quite sure she gave 2 tablets as ordered. The surveyor reminded the RCM that the medication had been removed from the Pyxis and there would be a record documenting that only one Norco was removed at approximately 7:36 am on 7/25/06. The RCM returned at 3:28 pm on 7/27/06 and stated, "[name of LN] did say she only gave one [tablet of Norco]." The LN was observed to administer the wrong dose of medication to a resident. 2. Resident # 1 was originally admitted to the facility on 10/19/05 and most recently readmitted on 5/23/06 with diagnoses including Quadriplegia, decubitus ulcer, osteomyelitis, pancytopenia, cirrhosis, diabetes mellitus 2, Methicillin Resistant	F 281	**Monitor:** **1.** Charge Nurses to notify RCMs daily, if no resident identification present, for replacement identification prior to medication or treatment being passed. **2.** Administrator to monitor audits **3.** Medication Error reports to be reviewed with QA process. **4.** DNS to conduct random audits of medication pass weekly for four weeks and then monthly thereafter.	9/2/2006

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F 281	Continued From page 35 Staphylococcus Aureus [MRSA], depression, neurogenic bladder, chronic anemia, and chronic leukopenia. During the observation of the medication pass on 7/25/06 at approximately 7:00 am, an LN was observed passing medication to resident #1. A total of 10 medications were given to the resident. Upon reconciling the resident's medications, the surveyor discovered the LN was not observed to administer a multivitamin as per the July 2006 physician's recapitulation [RECAP] orders. The multivitamin was documented as given at 8:00 am along with the resident's other morning medications. The LN was observed to omit an ordered medication from the resident's am medication pass. 3. Resident #3 was admitted on 4/28/06 with diagnoses which included CVA [stroke], hematoma of left leg, cataracts, glaucoma and dementia. An "Accident Or Incident Report" dated 6/17/06 revealed a medication error had occurred involving resident #3. Documentation included with the incident report included the following documentation: "At 0845 [8:45 am] on 6/17/06 the agency nurse asked the department head weekend manager if the resident next to her cart was [random resident #17], a newly admitted resident. The weekend manager who was walking past stated that it was [random resident #17] when in fact it was	F 281		

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F 281	Continued From page 36	F 281		

[resident #3]. The agency LPN then gave [resident #3] another resident's medications. The medications given in error were Kadian 20 mg [milligrams], Buspar 10 mg, Sinemet 10/100 mg, Tums 500 mg, Digoxin 0.125 mg and Lactulose 45 ml [milliliters]. All these medications were given by mouth.

After the medications were given the department manager realized that she had pointed out the wrong resident. The night shift LPN notified me (DNS) that the error had occurred. When questioning the night shift LPN she stated that there was not a picture of the resident in the MAR (random resident #17) and that [resident #3] did not have her wrist band on. [Resident #3's] wrist band was not on [resident #3's] arm. [Resident #3] has advanced dementia and she is unable to identify herself to staff..."

The report documented that resident #3's physician had been notified and her vital signs were checked every 15 minutes and then every 30 minutes. The resident passed a loose stool at 10:30 pm that same day but did not suffer any other adverse effects.

The facility audited MARs to ensure residents' pictures were present and the RCM performed an audit to ensure all residents were wearing arm bands.

The facility failed to ensure nursing staff had a means for identifying residents. This resulted in a medication error when an agency LN administered random resident #17's medications to resident #3.

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F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interview, it was determined that the facility did not follow plans of care and offer an alternate when a resident ate 50% or less of a meal. This was true for 1 of 11 sampled residents (#5) whose care plans were reviewed. The findings include: Resident #5 was admitted to the facility on 8/25/05 with the diagnoses of dementia, depression, osteoporosis, psychosis, and chronic back pain. Resident #5's care plan dated with a goal date of 10/27/06, documented, "Offer alternate if eats less than 50% of meal if alternate refused give a shake as meal replacement." On 7/24/06 at 2:12 pm, the resident was observed to be eating in the Sun Lounge dining room. The resident was asked if he was finished eating his lunch. He indicated he was and a NA took the resident's tray from him. The resident ate approximately 20% of his meal. The resident was helped back into his Merry Walker and wheeled to his room. Neither an alternate nor a shake was offered to the resident.	F 309	**Corrective Action:** Resident #5 has had a house supplement TID clarified to between meals. Care plan has been updated related to house supplement. Meal monitor has had shake added for clear documentation if alternative meal replacement refused post meal intake of less than 50%. **Identification:** All residents are identified as potentially being affected. **Systemic Changes:** **1.** Dietary Supervisor and DNS will inservice all nursing and dietary staff regarding meal replacement, meal supplementation, added supplementation for meal replacement refusal, and accurate documentation of consumption. **2.** Dietary Supervisor to audit all current residents' care plans to identify residents requiring supplementation post refusal of alternate meal and will add to meal monitor. **Monitor:** **1.** Dietary Supervisor and DNS to audit meal monitors weekly for compliance. **2.** Meal monitor process to be reviewed at QA meetings.	9/2/2006

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F 309	Continued From page 38 On 7/25/06 at 8:55 am, resident #5 was observed in the Sun Lounge dining room eating his breakfast. When the resident stopped eating, a NA asked the resident if he was finished eating and the resident did not respond back. The NA took the resident's tray. Several minutes later the surveyor asked the NA for the meal monitor sheets to see what was recorded. The July 25th meal monitor sheet recorded 10% and an R (refused) was recorded under replacement and house supplement. The NA was asked if he offered these items to the resident. The NA indicated that he just had. The surveyor was next to the resident the entire time and the NA did not offer these items to the resident. When the NA was made aware of this, the NA indicated that he did not offer them. He stated that he thought another NA had and thought that the resident had refused. That was why he had recorded the refusal. At this time the DNS was made aware of this. The DNS provided the surveyor with a copy of the meal monitor sheet and indicated that the resident should have been offered an alternate and a supplement. This is a repeat violation from the annual survey of 7/15/05.	F 309		

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F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure residents who required assistance with nail care and grooming received the necessary assistance. This was true for 2 of 11 sample residents (#'s 2 & 10) and 3 random residents (#14, 18 & 19). Findings include: 1. Resident #10 was admitted to the facility on 6/24/06 with the diagnoses of CVA [stroke] and dementia. The admission MDS assessment, dated 7/5/06, indicated the resident was severely impaired cognitively and required total assistance of one/or two person for all ADL's including hygiene. The resident was observed on 7/25/06 at 9:08 am with multiple long white hairs on her chin. The hairs were approximately 1/3 inch long. The resident was sitting in a wheelchair near the nurses station. On 7/28/06 at 9:25 am resident #10's nails on her hands were observed. The nails on the resident's left hand were yellow and discolored extending 1/2 inch from the end of the nail bed. The resident had dried exudate in her left eye and her forehead was very dry. The LN stated, at the time	F 312	**Corrective Action:** Residents # 2,10,14, and 19 have all had facial hair removed. Resident #18 has discharged from the facility. **Identification:** All residents are identified as potentially being affected. **Systemic Changes:** **1.** Nursing staff have been inserviced on ADL requirements for grooming. **2.** Licensed Nurse staff to complete daily audits to ensure compliance for resident grooming. **3.** Licensed Nurse staff to follow-up with CNAs for compliance if grooming not completed so task will be completed. **Monitor:** DNS to monitor audits for completion. Review at QA meeting for compliance.	9/2/2006

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F 312	Continued From page 40 of the observation, that the resident was only in the facility for respite care and she did not know when the family was taking her home. The resident had been in the facility for over one month. 2. Resident #2 was originally admitted to the facility on 7/31/03 and readmitted on 2/25/06 with diagnoses including Multiple Sclerosis, arthritis, hypertension, and depression. The most recent MDS, dated 6/08/06, documented the resident was totally dependent on staff for all cares including bathing and personal hygiene. On 7/24/06 at 12:24 pm, the resident was observed laying in bed watching television. The resident had multiple light-colored long hairs on her chin. The hairs were approximately 1/2 inch long. The resident was observed again on 7/24/06 at 3:03 pm in the dining room playing Bingo. The resident was observed with multiple long hairs on her chin. 3. Random resident #14 was observed on 7/25/06 at 8:46 am with long white hairs on her chin. The hairs were approxmately 1/2 inch long. She was again observed on 7/26/06 at 8:20 am during an observation of medication pass. The resident was seated in the dining room at the table and was observed with long hairs on her chin. 4. Random resident #19 was observed during the	F 312		

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F 312	Continued From page 41 initial tour on 7/24/06 at approximately 9:00 am. The resident was sitting on the bed in her room and was observed to have long white hairs on her chin. The hairs were approximately 1/2 inch long. The resident was observed again on 7/24/06 at 12:34 pm with long hairs on her chin. 5. Random resident #18 was observed on 7/25/06 at 2:50 pm with long white hairs on her chin. The hairs were approximately 1/4 inch long. The facility did not ensure residents received the necessary services related to grooming.	F 312		
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: 2. Resident #4 was admitted to the facility on 7/29/04 with the diagnoses of Multiple Sclerosis, dementia, neuropathy, restless leg syndrome, chronic pain, and urinary retention. The quarterly MDS assessment dated 3/10/06, indicated the resident had both short and long term memory problems and cognition was moderately impaired.	F 314	**Corrective Action:** **1.** Resident #4 has been discharged to an alternate setting (acute psychiatric) on 8/2/2006. **2.** Resident #1 will have added to TAR "no draw sheet under resident when on air mattress. Licensed Nurse to monitor each shift to ensure compliance. **Identification:** All residents on air mattresses are identified as potentially being affected. Continued on p. 43	

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F 314	Continued From page 42 The resident required total assistance of one to two people for bed mobility, transfer, ambulation, dressing, toilet use, and personal hygiene. The resident had no pressure ulcers. The most current quarterly MDS assessment, dated 6/2/06, indicated a stage II pressure ulcer. No other changes were noted for this MDS assessment. The Care Plan with a goal date of 6/15/06 documented the following: Under Mobility/Positioning, "...First to lay down [after] meals, last to get up before meals." Under fall prevention, "...Pillow along L[eft] side torso for bed postioning place under draw sheet." Under skin integrity/edema, "Problems:..at risk 2° [secondary] to [decreased] mobility related to MS [Multiple Sclerosis]...Approach: pressure relief on bed: pressure reducing/air overlay (this was crossed out and not dated and air mattress was hand written in), pressure relief on chair: pressure reducing, weekly skin at risk assessment... Float heels on pillow... Apply face cream & hand lotion twice daily, heel lifts on while in bed, air mattress (these items were hand written in without a date indicated when it was added to the care plan). On 3/13/06 a fax memorandum documented, "... [residents name] is at risk for skin breakdown may we have orders for air overlay mattress to bed [and] heel lifts on while in bed." The physician documented that he agreed and signed it on 3/15/06. Nursing notes on 4/20/06 at 4:40 pm documented, "...Noted R[right] buttocks [with] 2 small superficial open areas - blanches - cleaned	F 314	**Systemic Changes:** **1.** All residents on air mattresses will have added to their TAR, "no draw sheet under resident when on air mattress". Licensed Nurse to monitor each shift to ensure compliance. **2.** All Licensed Nurse staff will be inserviced on wound assessment, prevention plans, care plans, and documentation. **3.** All Licensed Nurse staff will be inserviced on appropriate documentation on Skin Progress Sheets. **4.** All skin issues will be reviewed weekly by the RCMs for prevention/resolution. **Monitor:** **1.** DNS will monitor weekly, all air beds/overlays for function and to ensure no inappropriate use of pads/draw sheets. **2.** All skin issues will be reviewed in the facility QA process for compliance.	9/2/2006

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F 314	Continued From page 43 and barrier cream applied..." From 4/13/06 through 4/20/06 the resident was noted to have no behaviors and was cooperative with cares, with the exception of 4/19/06 at 11:30 am when the resident was "...Striking out [and] scratching." A skin condition progress notes sheet documented resident #4 developed two open areas on the right buttocks on 4/20/06. On 4/21/06 this same form documented only one stage two pressure ulcer, measured at 2.7 cm [centimeters] in length by 2.7 cm in width. A CNA flow sheet documented that the resident was to have pillows along her left side of her torso positioned under the drawsheet when in bed. All but four shifts had initials for the entire month of April. There was no documentation found that the resident was to be repositioned in bed during this time. April 2006 recapitulation orders documented air overlay/mattress which was crossed out and dated 4/21/06 and air mattress was written in by hand. A physician telephone order documented on 4/21/06, "air mattress". A skin condition progress notes sheet documented the following on resident #4: *4/27/06 - Stage II, size - 2.7 cm length by 2.2 cm in width, color red, surrounding tissue - scar tissue, drainage - scant, no odor, response to treatment yes, change in treatment no. *5/4/06 - Stage II, size - 2.7 cm length by 1.8 cm in width, color red, surrounding tissue - scar tissue, drainage - scant, no odor, response to	F 314		

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F 314	Continued From page 44	F 314		

treatment yes, change in treatment no.
*5/10/06 - Stage II, size - 2.7 cm length by 1.6 cm in width, color red, surrounding tissue - scar tissue, drainage - scant, no odor, response to treatment yes, change in treatment no.
*5/18/06 - Stage II, size - 2.6 cm length by 1.7 cm in width, color red, surrounding tissue - scar tissue, drainage - scant, no odor, response to treatment yes, change in treatment no.
*5/25/06 - Stage II, size - 2.2 cm length by 1.7 cm in width, color red, surrounding tissue - scar tissue, drainage - scant, no odor, response to treatment yes, change in treatment no.
*5/30/06 - Stage II, size - 2.1 cm length by 1.6 cm in width, color red, surrounding tissue - scar tissue, drainage - scant, no odor, response to treatment yes, change in treatment no.
*6/6/06 - Stage II, size - 1.9 cm length by 1.5 cm in width, color pink/red, surrounding tissue - scar tissue, drainage - scant, no odor, response to treatment yes, change in treatment no.
*6/13/06 - Stage II, size - 1.9 cm length by 1.3 cm in width, color pink/red, surrounding tissue - scar tissue, drainage - scant, no odor, response to treatment yes, change in treatment no.
*6/28/06 - Stage II, size - 1.4 cm length by 1.0 cm in width, color pink/red, surrounding tissue - scar tissue, drainage - scant, no odor, response to treatment yes, change in treatment no.
*7/4/06 - Stage II, size - 1.1 cm length by 1.0 cm in width, color pink/red, surrounding tissue - scar tissue, drainage - scant, no odor, response to treatment yes, change in treatment no.
*7/7/06 - Stage II, size - 1.1 cm length by 1.0 cm in width, color pink, surrounding tissue - scar tissue, drainage - scant, no odor, response to treatment yes, change in treatment no.
*7/11/06 - Stage II, size - 0.8 cm length by 0.5 cm

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F 314	Continued From page 45 in width, color pink, surrounding tissue - scar tissue, no drainage, no odor, response to treatment yes, change in treatment no. *7/18/06 - Stage II, size - 0.7 cm length by 0.5 cm in width, color pink, surrounding tissue - scar tissue, no drainage, no odor, response to treatment yes, change in treatment no. The resident's wound was observed during a dressing change on 7/26/06 at 11:24 am. The wound was on the resident's right lower buttock, was approximately the size of a quarter, and the presence of granulation tissue was noted in the wound bed. The wound appeared to be a healing stage II pressure ulcer. On 7/26/06 at 8:15 am, the DNS was interviewed regarding resident #4's pressure ulcer. The DNS indicated that the resident was put on an air overlay and not an air mattress because air overlays are to prevent stage I and II pressure ulcers from developing. She also indicated that the resident was in bed a lot, should have been on a turning program and that the resident "must have slipped though the cracks." At this time the surveyor asked for the resident's care plan for the time the pressure ulcer in April developed. The DNS provided the care plan and indicated that they do not date the care plan, but could tell it was the care plan at that time because of the goal date. Resident #4 had a history of a pressure ulcer on the right heel in March of 2006 and was assessed by the facility at moderate risk for pressure ulcer development in April 2006. The facility failed to implement a turning schedule or put in place an air mattress before the resident developed a	F 314		

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	135090	A. BUILDING _____ B. WING _____	08/02/2006

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F 314	Continued From page 46 stage II pressure ulcer on the right buttock on 4/20/06. Based on observation, resident interview, staff interview, and record review it was determined the facility did not ensure 2 of 6 sampled residents (#'s 1 & 4) who were reviewed for pressure ulcers did not develop pressure ulcers. Findings include: 1. Resident # 1 was originally admitted to the facility on 10/19/05 and most recently readmitted on 5/23/06 with diagnoses including Quadriplegia, decubitus ulcer, osteomyelitis, pancytopenia, cirrhosis, diabetes mellitus 2, Methicillin Resistant Staphylococcus Aureus [MRSA], depression, chronic anemia, and chronic leukopenia. The resident was originally admitted with a stage IV pressure ulcer on the left buttock. A Braden assessment, dated 5/23/06, scored the resident at "13" or moderate risk for skin breakdown. An MDS, dated 6/5/06, documented the resident was totally dependent on staff for bed mobility, transferring, locomotion on the unit, dressing, toileting, personal hygiene and bathing. The resident's care plan was not dated but documented an admit date of 5/23/06. Problem #2 "Skin Integrity/Edema" addressed the resident's pressure ulcers with the goal "Resolve Current Skin Issues" and a target date of 8/23/06. The approaches documented for this problem included: "Airbed alternating pressure, Pressure relief on chair: Type: Pressure reducing, Weekly skin at Risk Assessment...Weekly Skin Progress Update for active skin conditions, RD [Registered	F 314		

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F 314	Continued From page 47	F 314		

Dietician] referral...Heel lifts on while in bed, Reposition q [every] 2 [hours]." The front page of the resident's care plan included an undated handwritten note that stated: "No draw sheet under Res[ident] in bed. Put foot of Bed [up] first then Head of Bed [up] to reduce shearing."

A temporary care plan documented a problem with an onset date of 6/11/06 and identified the problem as" Decub[itus] [right] buttock." The documented goal was "Area will be healed x 30 days" with a goal date of 7/11/06. The documented approaches included turning the resident every 2 hours, encouraging fluids, keeping the area clean and dry, treatments per the doctor's order, and an alternating pressure bed.

An admission assessment, dated 5/2/06, documented the resident had a wound VAC [vacuum assisted closure] intact on the stage IV pressure ulcer on the left ischial tuberosity. The assessment documented a "large area of redness on coccyx area. Hard to measure approximately 25.5 cm [centimeters] at widest point and 22 cm at longest point." The posterior anatomical diagram on the assessment form documented a circled area that was irregular in shape on a portion of the right and left buttocks. A handwritten notation documented "red cellulitis" with a line drawn towards the right buttock.

Documentation from May 2006 nursing notes revealed the following:

*5/8/06 @ 12:15 pm - "Alerted by CNA that res[ident] has an open area on [right] ischium. Measurements 1.2 cm x [by] 1.8 cm. Area [with]

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F 314	Continued From page 48	F 314		

bloody drainage. Res alert et [and] oriented able to make needs known. Res unable to state what happened d/t [due to] being a quadiplegic [sic]. Before the incident res was in bed. Environmental factors involved possibly from beddings causing skin to sheer [sic]...For prevention res is to be turned from side to side q 2 [hours]."

*5/9/06 @8:45 am - "Skin Tear Follow UP: Res returned from [hospital] on 5/2/06 R/T [related to] acute cellulitis episode R/T MRSA in Stage IV ulcer. Noted small skin tear to IT [ischial tuberosity] area most likely R/T sheer [sic] type area from turn. Res currently on air bed [with] blue Chuck [sic] under res, [no] linen present. POC [plan of care] [changed] to include that only a chuck [sic] pad is to be placed under res, also will [change] to an alternating pressure air bed in order to further ensure wound healing et to assist in preventing [illegible word] type injuries, res to still be turned on a regular basis et remains on bedrest per [name of physician] at the wound clinic. Res is cooperative [with] this POC plan et understands why this intervention is necessary. Continue [with] current POC that includes above mentioned [changes]."

Documentation from wound tracking sheets and skin condition progress notes was as follows for this specific wound:

*5/11/06 - Right ischial tuberosity wound - Stage II. Size = 1.2 cm x 1.8 cm. Documentation on this date also indicated the wound was not present upon admission to the facility.

*5/16/06 - Stage II. The size of the wound was 1.1 cm x 1.4 cm, the color was red, the surrounding

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F 314	Continued From page 49 tissue was clear/scar tissue and the drainage was documented as bloody. *5/25/06 - Stage II size 0.7 cm x 1 cm "Improving" *5/30/06 - Stage II, 0.7 cm x 1 cm in size, color = red and the surrounding tissue = scar tissue. The documentation indicated there was no drainage or odor present and the wound was responding to treatment. *6/1/06 - Stage II, 0.3 cm x 0.2 cm "Improving" *6/5/06 - The wound was documented as resolved. Documentation from June 2006 nursing notes revealed the following: *6/11/06 at 10:30 am - "During Drsg [dressing] [change] area on [right] buttock 1 x 1.4 cm noted. Scant amt [amount] red drainage [at] site. Skin around area intact. Pt is turned q 2 [hours] et on air bed. Pt. compliant [with] turning..." *6/12/06 @ 11:50 am - "[illegible word] to open are on Rt [right] Buttock. Res has Stage two to [right] Buttock. Area is interior to wound that resolved last week. Res is a Quad[riplegic] & on an Air bed. Wound could be the result of shearing or draw sheet left under Res. Will in-service staff not to leave draw sheet under Res & to put foot of bed up first before head to prevent shearing." The "Weekly Decubitus Report" documented the following information regarding the wound: *6/29/06 - Stage II, 2.2 cm x 1.3 cm, wound	F 314		

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F 314	Continued From page 50 treatment = Panafil/Bactroban foam *7/6/06 - Stage II 2.5 cm x 2.1 cm, wound treatment = Panafil *7/13/06 - Stage II 2.2 cm x 0.6 cm, wound treatment = Panafil, "Improving" *7/21/06 - Stage II 2 cm x 0.6 cm, Panafil & Hydrosorb, "Improving" The wound was observed during a dressing change on 7/25/06 at 11:10 am. The wound appeared to be a healing stage II pressure ulcer. No odor or other signs/symptoms of infection were noted. The area around the wound was not reddened. There was a small amount of bloody appearing discharge on the old dressing. An interview was conducted with the DON and 3 Resident Care Managers (RCM) on 7/26/06 at 11:55 am. The nursing staff indicated the first time the resident's pressure ulcer developed it was during a hospital stay. One RCM later stated that upon research, this was not the case. The resident developed the initial wound in the facility. An RCM stated the wound opened up again on 6/11/06. Staff alerted the RCM to the wounds presence and when she entered the resident's room, a draw sheet was under the resident. She stated she immediately in-serviced all staff about not using draw sheets under residents on air beds. She stated this was an isolated incident and draw sheets were not commonly used under this resident or any resident on an air bed. On 7/28/06, the surveyor observed resident #2, who was on the same type of air bed that resident	F 314		

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F 314	Continued From page 51 #1 was on, lying in bed with a white sheet underneath her. The surveyor asked the resident if a sheet was always under her when she was in bed and she said, "Yes...because I have accidents..." The surveyor left the room and returned with a RCM. The RCM saw the sheet under the resident and stated, "Oh no, that's not supposed to be on there." Two CNAs came into the room to transfer the resident. Both CNAs stated they knew the sheet wasn't supposed to be used but "...nights [night shift] uses it..." The RCM stated the night shift should not be using a draw sheet at any time and removed the sheet from the room. The facility failed to prevent a stage II pressure ulcer from developing on a resident who was known to be at risk. After the original pressure healed, the facility failed to ensure the wound was not re-opened. Facility staff indicated the wound re-opened because CNAs used a draw sheet under the resident when they were not supposed to. Nursing management stated this was an isolated incident but during the survey, a draw sheet was observed under another high risk resident on the same type of air bed.	F 314		

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F 315 SS=H	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and medical record review, it was determined the facility did not conduct assessments of incontinence, identify risks for urinary tract infection (UTI), develop and implement care plans timely, and provide approriate during catheter, incontinence and wound care to reduce or prevent UTI. This practice affected 5 of 11 sample residents (#1,2,3,7,8) and resulted in harm to residents #1, 2, 3 and 8. Resident #2 was hospitalized with pyelonephritis on 12/14/05 and with a urinary tract infection on 2/22/06. Between February and June 2006, the resident had 2 additional urinary tract infections. Resident #1 had a history of urosepsis and was hospitalized on 5/17/06 with a urinary tract infection. From December 2005 through June 2006, resident #1 had 4 urinary tract infections. The facility did not assess, care plan or implement a procudure to establish resident #3's continence after removal of a foley catheter. This resulted in the resident being total incontinent. Resident #8 had a supra pubic catheter in place and was at risk for UTIs. The facility did not assess resident #8 at high risk	F 315	**Corrective Action**: Residents #1, 2, 3, 7, and 8 were included in the corrective action and plan of correction that was completed on 07/28/06 and accepted by the Idaho Department of Health and Welfare. See Attached POC for reference **Identification**: All residents are identified as potentially being affected. **Systemic Changes**: Systemic Change Addendum: The Medical Director of Marquis Care at Shaw Mountain will review all urinary tract infections each week for further consult on additional preventative plans that may be used if applicable **Monitor:** See attached POC accepted by the Idaho Department of Health And Welfare for Monitoring programs. See Attached	9/2/2006

Marquis Care at Shaw Mountain
F315 IJ
Plan of Correction

Corrective Action:

1. DNS and Marquis Companies Clinical Support Staff (Sherry Brass, RN, and Dana Haase, LSW) will inservice all Nursing staff with regard to Urinary Tract Infection(UTI), Infection Control Prevention, identification, and treatment.
   Completion Date: 8/11/2006
   Person Responsible: DNS
2. A review of all existing residents with UTI, history of UTI, Incontinence, and catheter placement, regardless of type, will be completed to identify those residents at risk for UTI. This initial review will be completed by 8/1/2006 and then weekly for four (4) weeks and monthly thereafter.
   Completion Date: 8/1/2006
   Person Responsible: DNS
3. Licensed and CNA Staff to be inserviced on causes and prevention of UTIs, appropriate peri care, and catheter care. Inservicing of staff to begin immediatlely (7/28/06) Information used in inservice attached. DNS, Resident Care Managers, and Marquis Companies Clinical Support Staff to conduct inservice to staff through verbal instruction and demonstration. Staff will be required to demonstrate back the information and techniques demonstrated to them.
   Completion Date: 8/1/2006
   Person Responsible: DNS
4. Licensed staff to be inserviced by DNS, RCM, and Marquis Companies Clinical Support Staff as to development and implementation of resident care plans in a timely manner to ensure compliance with facility policy and procedure with regard to prevention of UTIs.
   Completion Date: 8/1/2006
   Person Responsible: DNS

Identification:

All residents are identified as being affected by this deficient practice.

Systemic Changes:

1. Administrator and DNS to review Weekly Infection Control report to identify trends and outcomes. This review is to be conducted weekly for four (4) weeks and monthly thereafter. This process will begin immediately. This will be an ongoing process.
2. All infections to be reviewed by Interdisciplinary Team (Administrator, DNS, RCMx3, Dietary Manager, Activities Director) during the facility's 24 Hour Report process to identify current infection causes and preventions. Records of residents that experience any change in condition , new orders, skin alteration, admission, wounds, incident or accident, etc. are put on "Alert Charting" and their record is reviewed by the IDT. This is an ongoing process.
3. Infections will continue to be reviewed in the facility's monthly Quality Assurance Committee Mtg. which includes the facility's Medical Director. Federal and State Regulations regarding urinary incontinence and UTI and infection control will be reviewed by this Committee Quarterly to ensure compliance.

Monitors:

1. Infections and care plans to be reviewed during the facility's 24 Hour Process by the IDT to ensure compliance
2. Infections to be reviewed by monthly QA Committee.

Person Responsible: Joe Rudd, Administrator

7/28/06 10:30pm

7/28/2006

RN 7/28/06 10:30 pm

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for UTI and had no documented preventative measures in place. Resident #8 was being treated for a urinary tract infection during the survey. Resident #7 had a Foley catheter in place without medical justification. Findings include:

1. Resident #2 was originally admitted to the facility on 7/31/03 and readmitted after being hospitalized for a urinary tract infection on 2/25/06 with diagnoses including Multiple Sclerosis, urinary retention, and history of urinary tract infections and pyelonephritis with stent placement. On 6/6/06, the resident had a suprapubic catheter placed. Prior to that the resident had a Foley catheter in place due to the urinary retention.

The most recent MDS, dated 6/08/06, documented the resident was totally dependent on staff for all cares including toileting, bathing, and personal hygiene.

The care plan was not dated but noted an admission date of 2/24/06 and addressed the catheter in problem 1, "ADL/Rehab." The care plan documented the resident had a suprapubic catheter and the following instructions: "suprapubic catheter. [check] site & apply [unable to read word] until healed. No! Leg Bag!" The care plan did not address the resident's history and risk for UTIs, goals, and interventions for prevention, and did not address routine catheter care.

There was no information in the resident's chart regarding a care plan for Foley catheter care prior to the suprapubic insertion in June of 2006. A Resident Care Manager (RCM) was interviewed

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F 315	Continued From page 54 on 7/28/06 at 11:05 am regarding resident #2 and Foley catheter care. The RCM stated, "...Foley cath care was never put on the care plan..." Nursing notes from 12/05 revealed the following: *12/14/05 at 6:45 am - "Res. [resident] given Dulcolax suppository for bowel care, noted res. [with] pupils fixed & dilated, not answering questions. Moist non-productive cough. T [temperature] 99.8. DK [dark] amber, cloudy urine in BSU [bedside unit]. BS [bowel sounds] very hypoactive, abd [abdomen] firm & distended...O2 [oxygen] SAT [saturation] 82% RA [room air]...order received to send to ER [emergency room]...order received at 4:35 am...res. transferred at 5:00 am..." A discharge summary dated 12/20/05 documented the resident had been admitted to a local hospital on 12/14/05. At discharge her diagnoses included "pyelonephritis, resolving status post ureteral stent placement December 20, 2005, for right renal obstruction." Nursing Notes from 2/06 revealed the following: *2/16/06 at 11:30 am - "received orders to start Levaquin w/repeat UA [urinalysis] on 3/1/06..." *2/17/06 at 2:15 am - "Continue on ABT [antibiotic] for UTI - urine dark [with] sediments..." *2/20/06 at 7:50 am - "...foley catheter patent of clear yellow urine [with] white sediment..." *2/20/06 @ 10:00 pm - "...ABT therapy for UTI continues [without] adverse reaction - fluids taken	F 315		